



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTHWEST TEXAS HOSPITAL
1208 LAKE WOODLANDS DR STE 4024
THE WOODLANDS TX 77380-5010

Respondent Name

AMERICAN HOME ASSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-2109-01

MFDR Date Received

February 10, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...Total charges of \$1,781.60. We received payment of \$503.23. I filed the appeal for underpayment on 7/6/10 & didn't receive additional money. I spoke customer service at Chartis, and they stated that the claim was processed using the Focus/Aetna contract. Our contract termed on 10/12/09. I have attached a copy of the contract termination letter. The account is still underpaid in the amount of \$508.63. "

Amount in Dispute: \$508.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Respondent was notified of medical fee dispute on March 3, 2011. No response submitted.

Response Required by: American Home Assurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 7, 2010	Outpatient Hospital Services	\$508.63	\$359.84

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the

reimbursement guidelines for facility services provided in an outpatient acute care hospital.

3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.
5. 28 Texas Administrative Code §102.4 sets out general rules regarding communications.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated June 14, 2010

- 1- Please provide the appropriate CPT code, HCPCS code, or state-specific code for this service and resubmit for payment
- 2 – This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business.
- 3 – The charge for this procedure exceeds the fee schedule or usual and customary allowance
- 4 – Recommendation of payment has been based on this procedure code, 97597, which best describes services rendered.
- This bill was paid according to fee schedule/usual and customary guidelines. No additional payment is recommended.
- Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review

Explanation of benefits dated July 29, 2010

- 1- Please provide the appropriate CPT code, HCPCS code, or state-specific code for this service and resubmit for payment
- 2 – This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business.
- 3 – Any reduction is in accordance with your Aetna contract. Aetna is part of the Coventry network through Aetna's lease arrangement with Coventry. For questions regarding contractual reductions, please call 1-800-238-8288.
- 4 – Authorization for treatment should have been obtained by the provider prior to rendering services. Verification of authorization is recommended prior to payment.
- 5 – Recommendation of payment has been based on this procedure code, 97001, which best describes services rendered.
- 3 – The charge for this procedure exceeds the fee schedule or usual and customary allowance
- This bill was paid according to fee schedule/usual and customary guidelines. No additional payment is recommended.

Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 3 – “Any reduction is in accordance with the FOCUS-Aetna Workers Comp Access LLC contract and This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business. For questions regarding contractual reductions, please call 1-800-238-6288.” Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. No documentation was found to support that the health care provider had been given notice, in the time and manner required by 28 Texas Administrative Code §133.4, that the insurance carrier had been granted access to the health care provider's contracted fee arrangement at the time the disputed services were rendered. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation

used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 97597, date of service May 7, 2010, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0015, which, per OPPS Addendum A, has a payment rate of \$103.89. This amount multiplied by 60% yields an unadjusted labor-related amount of \$62.33. This amount multiplied by the annual wage index for this facility of 0.8594 yields an adjusted labor-related amount of \$53.57. The non-labor related portion is 40% of the APC rate or \$41.56. The sum of the labor and non-labor related amounts is \$95.13 at 6 units, with multiple-procedure discount, is \$332.96. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total APC payment for this line is \$332.96. This amount multiplied by 200% yields a MAR of \$665.91.
 - Procedure code 97597, date of service May 7, 2010, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0015, which, per OPPS Addendum A, has a payment rate of \$103.89. This amount multiplied by 60% yields an unadjusted labor-related amount of \$62.33. This amount multiplied by the annual wage index for this facility of 0.8594 yields an adjusted labor-related amount of \$53.57. The non-labor related portion is 40% of the APC rate or \$41.56. The sum of the labor and non-labor related amounts is \$95.13. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total APC payment for this line, including multiple-procedure discount, is \$47.57. This amount multiplied by 200% yields a MAR of \$95.14.
 - Procedure code 97001, date of service May 7, 2010, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is \$69.25. This amount divided by the Medicare conversion factor of 36.8729 and multiplied by the Division conversion factor of 54.32 yields a MAR of \$102.02. The recommended payment is \$102.02.
4. The total allowable reimbursement for the services in dispute is \$863.07. This amount less the amount previously paid by the insurance carrier of \$503.23 leaves an amount due to the requestor of \$359.84. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$359.84.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$359.84, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

March 21, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.